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DiabetesWatch

A publication of the PHILIPPINE DIABETES ASSOCIATION, INC. for the Filipino diabetic patient

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Where we belong . . . . .

In the past two issues, we featured the logos of the international and regional associations to which the Philippine Diabetes Association belongs. These logos are in fact on the bannerhead of DiabetesWatch.

The bird on the International Diabetes Federation (IDF) logo is a hummingbird – chosen because of its qualities – intercontinental liasion, metabolic adaptation, energy and courage. On the other hand, the spiral design on the Western Pacific Region of the IDF logo, is that of the nautilus shell, a shell that is only found in the Western Pacific. The shell was chosen because of its beautiful form and harmony which has so long lasted on this earth and which signifies eternal development.

In this issue, a past president of the Philippine Diabetes Association (PDA) traces the meaning of the association's logo.

The PDA LOGO

GONZALO F. AUSTRIA, M.D.
A Past President, PDA

Since the establishment of the Philippine Diabetes Association in 1958, there had been a good number of changes in officers, working staff and its official headquarters. As a result, most of the society's records plus the original Logo were misplaced or got lost. The past history of the association can be partially gleaned from the memories of those who are still around to tell the tale. The moral that I can think of from this sad turn of events is: An organization as important as the Philippine Diabetes Association, should have as much as possible, a permanent home. This sounds like an invitation to all people interested in Diabetes, – doctors, patients, benefactors, everybody, – to take note and face the challenge. In fact, as a past president of the PDA, I can still recall the valiant efforts of Dr. Basilio Valdes and the rest of us to establish a home for the association. My memory tells me that the Araneta Family (this is where I'm not sure, Vicente or Antonio) had promised Drs. B. Valdes, Agustin Liboro and a few others a lot in what is now Araneta Avenue (near the front of Magsaysay Memorial Hospital), for the PDA. This is the beauty and fascina-

(Continued on page 2)

MARIA IMELDA Q. CARDINO, RND, MSFN
Diabetes Educational Clinic
Makati Medical Center

Diabetic patients of today are prescribed a high carbohydrate, high fiber diet. Gone are the days of severe restriction of starches for diabetics. This liberalization of carbohydrate is a result of years of study to find out what sort of diet would best maintain blood glucose within the normal, keep weight within the recommended range, and promote an over-all status of well-being for the patient.

Carbohydrate is known as the cheapest energy source. The Asian diet contains liberal amounts of carbohydrates. The Filipino diet in fact has about 70% carbohydrate content. Emphasis, however, has been on complex sources such as unpolished rice, oatmeal, whole kernel corn, rootcrops, and vegetables. Limits have been set for the intake of simple carbohydrates such as fruits because of the high glycemic response they cause.

What about fiber? First, the kind of fiber of nutritional importance must be identified:

Dietary fiber – This includes that portion of plant cells that are resistant to digestive enzymes in humans. However, although carbohydrate from fiber is not directly available in the human body, fiber can be degraded by the gastrointestinal microflora to become partially available to humans. Examples are soluble fibers such as pectins, gums, and some hemicelluloses. The term dietary fiber refers to a variety of plant substances such as celluloses, lignins, and mucilages plus the given examples of soluble fiber. The dietary fiber content of foods is two to six times higher than the crude fiber content.

Crude fiber – The remaining residue after the plant food has been treated with dilute acid and alkali is called crude fiber. Crude fiber includes only cellulose and lignin, the examples of insoluble fiber. Cellulose refers to the plant cell-wall structural component such as wheat bran and rice bran. Lignin refers to the woody structure in plants such as those found in old vegetables. From the nutritional standpoint, lignin does not contribute significantly to fiber intake for humans because of its unpalatable woody texture.

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IDF-WPR

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Update: Fibers . . . (From page 1)

Food composition tables will give the crude fiber content of foods and not the dietary fiber. This is because of the lack of adequate methods for analysis.

Roughage – The term is sometimes used to mean "fiber." This is because of the belief that some foods have an "Abrasive Quality." This term is not useful in the light of present knowledge.

Dietary fiber is very beneficial. Some amount of it is necessary to maintain normal gastrointestinal tract functioning. It has been associated with a flattened postprandial glycemic response among diabetics. It is also being given as a diet supplement to patients with hyperlipedemia. The gut mucosa is not exposed to carcinogenic substances because of faster transit time. For patients on low calorie diets, fiber gives them a feeling of fullness thereby helping them get adjusted to the reduced food intake.

It is also important to note that fiber-containing foods – vegetables (including legumes, beans, and peas), fruits, cereals, and grains, – contain a mixture of dietary fibers as well as vitamins, minerals, and essential nutrients. Individuals are encouraged to increase fiber intake from natural foods rather than fiber supplements. The following are good sources of fiber:

1) legumes like monggo, kidney bean, soya bean, etc.

2) tubers and rootcrops such as camote, gabi, tugi, etc.

3) green, leafy vegetables

4) all types of whole grain cereals such as oatmeal, barley, corn

5) fruits like guava, tiesa, sampaloc, chico, datiles, anonas, etc.

6) rice bran which can be added to white rice, cereals, etc.

The minimal discomfort one may experience when fiber is increased in the diet is outweighed by the many beneficial effects it gives. This can be attested to by the many patients of the Diabetes Clinic of the Makati Medical Center who are regular consumers of the bran. Since the clinic has introduced the bran to its patients over a year ago after the UP-PGH team completed its research on the then lowly "darak," their blood glucose control has markedly improved. For those who have not tried it, maybe now is the time.

The PDA Logo . . . (Continued from page 1)

tion of history (if we have the records), – I hope some beautiful and philanthropic soul can dig this up.

Now comes the Logo. I have explored 3 quarters: the present and immediate past office of the association, the medical library of the University of the Philippines College of Medicine and the Security and Exchange Commission. Unfortunately, no Logo. And no trace of the minds of the designers or the decision-makers of the PDA Logo.

Our best reproduction of the PDA Logo is what we can see in the DiabetesWatch. I can only put down my own interpretation of that Logo, based on my over-all experience and understanding of the subject.

I recognize 3 principal parts of the Logo: 1. the Staff of Aesculapius, 2. the Cup and probably, 3. a beehive in the background.

1. The Staff of Aesculapius consists of a snake entwined around a rod. This staff is always a representation of Aesculapius, the God of Medicine (in Roman mythology). This is the most common representation of medicine in our medical education.

2. The Cup is the cup of knowledge and conceivably contains the syrup of diabetic knowledge that everybody interested in diabetes would like to drink or would like to add to its contents.

3. The beehive is the living place of the bees which manufacture honey. Honey represents Diabetes. The common disease, Diabetes is more completely, Diabetes Mellitus or Honeyed Diabetes, Sugared Diabetes, or Sweet Diabetes. This term contrasts with another less common diabetes to the layman, Diabetes Insipidus, i.e. Insipid Diabetes, Diabetes without flavor or savor; thus, unsweetened diabetes. The background therefore symbolizes the world of Diabetes Mellitus of the Philippine Diabetes Association.

SEGUNDO L. LANSANG, M.D.
Internist-Diabetologist
UST Hospital

Diabetes and Exercise

The four basic principles in the care of a diabetic are: Diet, exercise, medication (either oral anti-diabetic agents and/or insulin) and education of the patient regarding his illness. Exercise is just as equally important as the others. In general, regular exercise has been found to lower blood glucose and liquid levels, makes one physically fit, helps improve the figure, lowers the incidence of heart disease, etc., in short, it improves the quality of life not only of diabetics but of non-diabetics as well. Even only a moderate increase in physical activity will impart well being.

There are two main types of exercise training: 1) Endurance training such as brisk walking, jogging, swimming, cycling, tennis, etc. 2) Strength training such as weight lifting, push ups, etc. Of these two, the first one is better. Exercise does not have to be strenuous, especially if you have been sedentary or inactive for quite a time. It is better if you consult first your physician and or a cardiologist before starting, especially for elderly or hypertensive patients. Young insulin dependent patients should consult their physician first. Common sense is needed. Choose any activity that you enjoy doing such as walking, gardening, dancing, climbing up and down the stairs, swimming, etc. Many patients complain that it is so hot in our country, so exercise, either in early morning or early evening. Some people complain that they can't exercise because of the rainy season; try walking briskly inside the house, try to make the floors of the sala bright and shiny with the use of a coconut half shell or "bunot," rearranging the furniture, cleaning the garage or rearranging the contents of your aparador, etc., you might even find items that you have misplaced long ago. Some people buy sophisticated or expensive items just to exercise; like stationary bicycle, electrical massager, weight-lifting devices, etc. You don't have to spend much to exercise.

One benefit of regular exercise also is weight reduction especially if one is overweight or obese. It improves the figure. The more active one is, the more calories one burns. Being active can help in the management of stress, also. If one is upset or angry, don't just sulk, and cry one's heart out, or flop oneself in front of the television and start eating; go out and walk in the park or go to these air conditioned shopping malls, etc., and just walk briskly (not window shopping) and before you know it the stress and anger have gone.

Some tips to remember; Check with your physician and or cardiologist first before embarking on an exercise therapy; wear comfortable and sturdy shoes, dress properly, always bring some candies with you, because you might develop hypoglycemia (too low blood sugar) as manifested by dizziness, sweating, sudden weakness, tremors, etc. Don't overdo exercise, just like in everything else, moderation is the key word.

Impotence is a subject, many diabetic men are unwilling to discuss with their physicians, but to most of them, there may be hope.

THE SUN MAY STILL RISE

AUGUSTO D. LITONJUA, M.D.
President, PDA

Most men feel that the development of impotence or decreased libido heralds the inescapable truth of aging, just as most women wrongly perceive the onset of menopause as their sexual twilight zone.

This belief of correlating decreased sexual libido with age has been nurtured since 24 centuries ago, dating back to the Golden Era of Athenian civilization.

The renowed French physiologist, Brown Sequard, in an apparent attempt to stave off old age, injected himself with an extract of testes. Though the preparation, which was watery in character, contained minimal if any active principle of the testes (testicular hormone is soluble only in fatty solvents), he reported that his vigour and capacity for work improved. Thus, people believed that the symptoms of old age were traceable to the failings of the male gonads, and that impotence and decreased libido were reflections of this failure. On the other hand, the Bible contains anecdotes of men fathering children at a very old age. Whereof lies the fact?

To many men, being impotent is like living the hermit's existence. It is said that the ability to be potent is the ability to communicate with a loved one. Thus, impotency is the deprivation of a communication channel – the deprived one now in solitude.

But first, what is the mechanism for potency?

Many confuse impotence with infertility. Masters and Johnson describe impotence as the inability to achieve or maintain a quality of erection sufficient to accomplish successful coital connection. This condition must assume a pattern of repeated erectile inadequacy occurring over a period of time. It excludes the "once in a while" failure when the man is tired, too drunk, or is not with the right partner. On the other hand, infertility is the inability to beget children, and this is related to spermatogenesis. Thus, one could be potent but infertile, or impotent but fertile.

There are many conflicting studies in medical literature about age-related changes in the hormonal and spermatogenic capacities of men. Many agree, however, that the vast majority of healthy elderly men maintain their reproductive capacity. One case of paternity at age 94 is documented – there may be several more which are unreported. The fact remains that the definable changes in gonodal function with advancing age are small. And the "routine" use of male hormones to maintain machoism is unwarranted if not dangerous in instances when diseases of the prostate gland are present but undiagnosed.

Potency is therefore a matter of erection. And erection is achieved through a combination of nervous and vascular mechanisms.

The nervous mechanisms initiate erection – the tactile stimulation of the genitalia or erogenous zones of the body transmit signals to the centres in the spinal cord, which in turn responds by causing the vasodilation (the arteries widen up to contain more blood) of the penile arteries to increase the blood flow into them. The spinal centres are also responsive to signals from the higher centres of the brain, explaining why erection can also be achieved through thought processes.

The male organ consists of the glans or head and the elongated shaft which is covered by loose skin. There is a tough tube under the skin called the tunica albuginea which encloses the urethra and two tubular bodies called corpora cavernosa. The urethra is what males void and ejaculate through. The corpora cavernosa are spongelike structures which can become filled with blood and stiffen the penis.

Thus, deficiencies of erection may find explanation in abnormalities of the nervous system and/or the blood vessels. And there is a definite association of impotence with aging. Kinsey showed a prevalence of 18.4 per cent by age 60, 27 per cent by age 70, 55 per cent by age 75 and 75 per cent by age 80. In contrast, impotence is relatively rare in the 20s and 30s. Psychologic and sociologic factors, as well as the general health status of the male, affect the sexual performance in the aging man.

Dr. Lawrence Martin, director of the sexual dysfunction unit of the Cleveland Clinic, believes, however, that many cases of erectile impotence are highly treatable. And the thesis begins with the recognition

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Impotence

A guide to treatment for this common problem.

JOHN E. MORLEY, M.D.
Reprinted from Diabetes Forecast
June, 1988

Impotence may be difficult to talk about, but it's extremely common. Today, however, doctors consider all impotence treatable. What's more, there is no age at which sexual activity is no longer possible.

Impotence is the physical inability to have an erection adequate for sexual intercourse. Although impotence was once considered a psychological problem, its main cause in men over 50 is now believed to be physical. It affects up to one man in three over 40 who has a medical problem, like diabetes, In fact, approximately one-third of all men who have diabetes – insulin- or non-insulin-dependent – are impotent. The onset of impotence depends on how long the diabetes has been present and how well controlled it has been. It is likely that good blood-sugar control can help to avoid diabetes-related impotence.

Why Am I Impotent?

There are many reason men become impotent, and any one of them may be the source of the problem in the individual with diabetes.

■ *Blockage.* The most common cause of impotence is atheroma (cholesterol deposits), which reduces blood flow through the penile artery. The artery to the penis is medium-sized, similar to the coronary arteries that supply blood to the heart. As the man with diabetes ages, the chance of developing a blockage in any of these vessels increases, particularly if the diabetes is poorly controlled and the individual has high levels of blood cholesterol.

In many cases, impotence due to blockage of a penile artery is an early warning sign of arterial disease elsewhere in the body. Men who are impotent because of vascular blockages have a higher likelihood of heart attacks and strokes. That's one reason impotence is a problem that needs to be taken seriously both by the patient and the physician.

■ *Medications.* Medications are the second most common cause of the problem. Sixteen out of the top 200 prescription drugs in America may cause impotence. Most commonly responsible are diuretics, such as hydrochlorthiazide, and antihypertensive agents that control high blood pressure, such as propranolol and methyldopa.

Less likely to cause such difficulties are the other antihypertensive agents, such as the calcium channel blockers, vasodilators, and angiotensin-converting enzyme inhibitors. Your doctor may switch you to one of these if you become impotent on an antihypertensive drug.

Men who become impotent when taking a drug often stop taking their medication without telling the physician. That is not the answer. High blood pressure itself, when untreated, will eventually make the vascular disease worse and that may cause impotence or other more serious problems.

Men with diabetes cannot afford to skip their antihypertensive drugs. Poorly controlled blood pressure can cause other serious consequences involving the kidneys and eyes.

If you become impotent after starting on a medication, discuss it with your physician. In most cases a solution can be found.

■ *Low testosterone.* The third major cause of impotence is the body's failure to produce adequate amounts of the male sex hormone, testosterone. In some men, testosterone levels become lower with advancing age.

Althought diabetes itself does not appear to reduce testosterone levels, some men with diabetes may develop elevated levels of another hormone called prolactin, which blocks the action of testosterone. If prolactin levels are elevated, they can be restored to normal by the drug bromergocryptine.

■ *Thyroid disease.* Thyroid disease is another treatable cause of impotence.

■ *Neuropathy.* Another cause of impotence in men with diabetes is damage to the nerves (neuropathy). Neuropathy can involve the nerves that control the penile blood flow (autonomic neuropathy) or nerves that receive the sensations coming from the penis (sensory neuropathy).

■ *Zinc deficiency.* Zinc deficiency is a rare but treatable cause of impotence. Diabetes causes zinc to be lost in the urine. In some older men, a zinc deficiency develops.

How Can I Avoid Becoming Impotent?

Two factors have been strongly associated with impotence in men with diabetes. They are poorly controlled diabetes, and excessive alcohol use.

There's a third way to avoid impotence, especially if you have diabetes. Don't smoke. Smoking causes blood vessels to constrict and worsen artery blockages. Since artery blockage is a major cause of impotence in men with diabetes, the man who does not want to become impotent will not smoke.

Psychological Reasons

When a man becomes impotent, even occasionally, he may become anxious about his ability to engage in sexual intercourse. We call this performance anxiety. Sometimes, the man may become so worried about impotence that he avoids sexual contact.

In some cases, just being aware of what is going on can lead to a cure; in others, counseling may solve the problem.

Another cause of impotence is the fear of becoming impotent. Men hear so much about impotence being associated with diabetes that they expect it to happen. They may then become impotent. Stress, in itself, can lower testosterone levels, aggravating the psychological impotence.

Older men who lose their wives go through a period of bereavement. If they form a companionship with another woman during this time, they may find they cannot have intercourse. Known as widower's syndrome, this condition is fairly common.

Science is changing long-held beliefs about psychological impotence. Some symptoms once thought to be purely psychological are now known to be physical at times. These include intermittent impotence; early morning erections, but loss of sexual erections; impotence that can be overcome by strengthening the stimuli, e.g., a new partner. We know that physical impotence may be associated with soft erections not hard

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Impotence . . .

(From page 5)

enough for vaginal penetration or with erections that disappear once the penis is inserted into the vagina. However, premature ejaculation is almost always psychological and responds well to sex therapy.

Tests When You Are Impotent

The most important test to have when you are impotent is an assessment of the blood flow in the penis. This test is known as the Doppler ultrasound technique. It can be given when the man is at rest or after exercise, since exercise causes the blood to flow to the buttocks and away from the penis. The Doppler is equivalent to the stress electrocardiogram for people with angina (heart trouble).

The physician can also do blood tests to determine male hormone levels and thyroid function. In some cases, a urologist may infuse saline (a salt solution) into the penis to check for any vein leakage, which can be repaired by surgery.

An important note is worth adding. To get insurance reimbursement for the treatment of impotence, you must prove that you cannot obtain an erection. A machine known as a nocturnal penile tumescence monitor can monitor erections – or lack of them. This test needs to be administered at a special sleep lab for three consecutive nights and is very expensive. In most cases, a simple device, a "snap gauge," can be substituted for this very expensive test. This apparatus fits around the base of the penis and has three thin wires that break at different strengths. If two or three of the strands are broken after a night's sleep, it's assumed the erection was adequate for intercourse.

Prosthesis

For the majority of patients who have diabetes and are impotent, the most effective therapy they can try is a penile prosthesis.

Two basic kinds of prostheses are available today. Both have two hollow cylinders placed inside the penis, one on either side of the urethra (the canal through which urine passes from the bladder).

One type is semi-rigid and can often be put in under a local anesthetic. This type of prosthesis contains a core of silver wire or stainless steel and can be bent to a flaccid or erect position. It is the least expensive of the two, costing less than $1,000.

The second, the inflatable prosthesis, costs approximately $4,000 and requires placement under general anesthesia. The man can activate the pumping device at will and maintain erection for as long as desired. However, in our experience, men with arthritis have had problems manipulating the pump. Also, the device is also more likely to break down than is the semi-rigid prosthesis.

A third type of prosthesis combining some features of the other has recently become available. It, too, runs about $4,000. This prosthesis also has two cylinders. However, the prosthesis is inflated by squeezing the shaft of the penis. Because long-term experience with this prosthesis is not yet available, it cannot be recommended without reservation.

Possible side effects of penile prostheses are: infection, erosion of the skin, and pain occurring in a very small percentage of patients. However, once the prosthesis is in place, most men do find satisfaction with it, whether the prosthesis is the semi-rigid or the inflatable type. Overall, we recommend a penile prosthesis in the majority of our patients with diabetes, but we feel it is important that the couple choose together whether the man should have a penile prosthesis.

Vacuum Tumescence

In this method, a container is placed over the penis, and a pump evacuates the air. This creates a vacuum. This treatment produces an erection, even in some patients with vascular disease. The man then stips a rubber band over the base of the penis to maintain the erection while he has intercourse. The rubber band must not be kept on for longer than 20 minutes to prevent damage to the penis. Bruising the penis may occur in some patients. The long-term effects of this treatment are not known, but some men and their partners find this an acceptable alternative to a penile prosthesis.

Other Therapies

Administration of the male hormone testosterone to men who have low male hormone levels may help. Testosterone may be injected or taken orally.

There are, however, side effects when testosterone is given in large doses. The most important of these is growth of the prostate. Because of this, it is essential that a physician perform a rectal examination before starting testosterone therapy and at six-month intervals thereafter. Other side effects can include painful nipples; a mild degree of water retention, which can lead to swollen ankles; and, in some cases, an increase in the red cells in the body, which can lead to thrombosis (blood clots).

Recently, physicians have found that injecting certain drugs directly into the penis will produce an erection. The drugs most commonly used are papaverine and phentolamine. Check with your doctor to find

(Continued on page 7)

The Sun . . . (from page 4)

that impotence can be of psychogenic or physical origin, and a competent physician may be able to differentiate between the two.

Psychogenic impotency, usually related to a depressive state or to an anxiety state, can be reversed when the affective state can be corrected.

Impotency from physical causes provides a long list of conditions causative of it. We shall deal with a few of them.

Use of drugs represents an increasingly more common cause of impotence. Middle aged and elderly men are treated for a variety of disorders, and many of these drugs can produce impotence, but happily, a reversible type of impotence once the usage of the drugs is corrected or adjusted.

Antiautonomic drugs, used for the treatment of high blood pressure or depression, interfere with the nervous signals causing erection. Other drugs produce impotence by diminishing libido or the sex drive, such as the hypotensive agent, spironolactone. Sedative-hypnotics and narcotics also suppress libido by their sedating or depressing effects on the sex centres of the brain.

Impotence . . . (from page 6)

out more about these drugs and their side effects.

With modern therapeutic advances, there is no reason for any man with diabetes not to have his impotence treated. Sexual function represents a major quality of life that all patients should feel free to discuss with a physician, and that both of them should take seriously.

John E. Morley is Professor of Medicine and Director of Geriatric Research in the Education and Clinical Center of the Veterans Administration, Sepulveda, California, and the UCLA San Fernando Valley Program.

This is not meant to be a complete review of the diagnostic aids and treatment regiments for impotency, but is meant to make the patient aware that such exist so that he may talk over his problems with his physician. Also, this is meant to complement the two articles on the subject which appear in this issue of DiabetesWatch.

And thus, inquiry as to the type of drugs one may be using can lead to the cause of the correctible impotency.

Alcoholism can produce impotency by poisoning tissues involved in the metabolism of the sex hormones, such as the liver, testes and pituitary gland. Alcohol can also affect the nervous system transmitting the signals for erection, and by suppressing libido through depression of the sex centres in the brain.

Diabetes mellitus is a very common cause of organic impotence through the effects of the high blood sugar in the arteries and on the nerves. Sometimes, the presence of diabetes is first suspected by the complaint of impotence.

A variety of laboratory studies and procedures can now pinpoint the cause of impotence, and many are treatable. If there is irreversible organic impotence, the man may be helped through penile prosthesis. In many cases therefore, impotence should not be accepted as the rewards of the damned, but may be treatable so that man's other use of his sexual activity, since reproduction may no longer be his purpose, may be serviced, e.g., to serve his personal needs and "the societal needs for stability by promoting pair bonding and stable family formation."

Reprinted from TAI-PAN, January, 1989.

Some Aids in the Treatment of Impotency in the Diabetic Male

Diagnosis

An 'effective' tho crude way of documenting organic impotence is by the 'stamp technique' – wherein at bedtime, stamps are placed around the stump of the penis. Erection is supposed to have taken place in sleep when the stamps have separated at their perforations when the man wakes up in the morning. A more accurate way is by the snap-gauge impotence testing device pictured in Figure 1. The device's snap elements give a reading of erection at sleep, which can help the physician determine if the patient's impotence is psychologically or physically based.

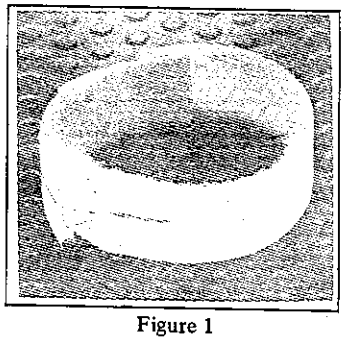


Figure 1

Treatment

Once the diagnosis of organic impotence is made, erection can be accomplished by surgical or non-surgical means (since male hormones are used only if it is determined that the patient's testosterone is low).

A surgical method is the implantation of malleable cylinders made of silicone rubber with a core of coiled silver wires embedded within. The silver core can be easily positioned manually to either the resting state, or to the erect position for intercourse (Figure 2). Another technique provides a reservoir placed in the scrotal sac to provide flaccidity or rigidity.

Non-surgical methods are also available, such as in the Correctaid erection assistance device. The hollow, soft elastic device is put on the penis by creating a vacuum inside the device. Once tumescence (rigidity) is achieved, the tubing is clamped (E in Figure 3) and wrapped around the base of the device. Tumescence is supposed to be retained as long as the device is worn. This is only one of the several non-surgical devices that utilize vacuum to achieve penile tumescence.

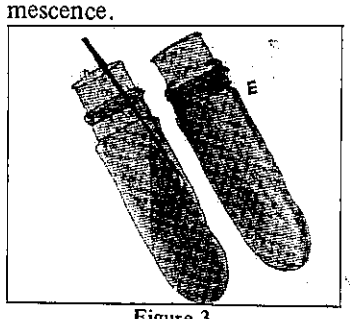
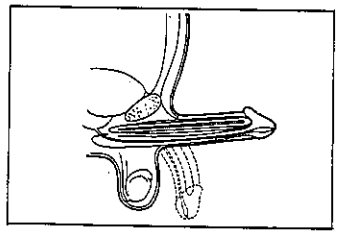


Figure 3

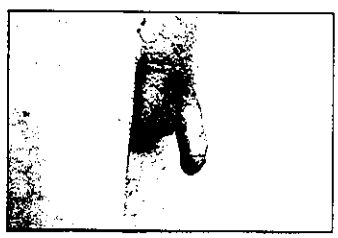
The above is published to give the impotent male hope that his affliction can be helped. It is emphasized, however, that consultation with his physician is mandatory to enable the patient to know whether he is a candidate for the above aids or not.

– A.D. LITONJUA, M.D.



Side View/Erect

Figure 2



Side View/Resting

NEWS

More PDA Chapters Organized

Lay Members in PDA Board of Directors Known Up to Year 1996

In a recent meeting of the PDA Board, it was unanimously approved that the two seats in the PDA Board alloted to lay members will be given to members of the pharmaceutical companies who have been supporting the activities of the Society. The two representatives from the designated companies will have a tenure of one year, and only the professional members of the Board will be elected at the Annual Convention, and will have a tenure of two years. There are seven professional members.

The agreed upon lay membership in the Board follows:

1991: Becton-Dickinson and Eli Lilly

1992: Med Asia and Boots Company

1993: Hoechst and ER Squibb

1994: Farmitalia Carlo Erba and Novo-Nordisk

1995: Pfizer and Boehringer Mannheim

1996: Ames and Wyeth Suaco

Donation

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SGV DEVELOPMENT CENTER
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1200 MAKATI, METRO MANILA, PHILIPPINES

May 14, 1990

Philippine Diabetes Association
Gentlemen:

I am pleased to enclose Security Bank Check No. 344343 dated May 8, 1990 for ₱3,820.00 which I am donating to your organization.

I hope that this donation will be of some help in achieving your organization's objectives.

Very truly yours,

Antonio R. Geronilla
Principal

Four more chapters of the Philippine Diabetes Association have been organized, three in the Bicol region, and one in Laguna. This brings the number of chapters of the PDA to a total of 20.

As a first project of the chapter, a diabetes educational clinic is set up to service the patients of the community. Training has been done during a 1½ to 2 day intensive course conducted by the teaching team of the Diabetes Educational Clinic of the Makati Medical Center which is composed of: Ms. Imelda Q. Cardino, dietician; Ms. Vicky Santiago and Ms. Susan Trinidad, teaching nurses; and the endocrine fellows of the Makati Medical Center and the University of the Philippines-Philippine General Hospital (UP-PGH).

Recently, the chapters organized with the help of Boehringer Mannheim, Med-Asia and Eli Lilly Pharmaceuticals were the Camarines Chapter (Camarines Sur and Camarines Norte), Laguna Chapter, Sorsogon Chapter and Albay Chapter.

Camarines Chapter

President – Dr. Efren Narva; Vice President – Dr. Lope Semana; Treasurer – Dr. Evangeline de Guzman; Secretary – Dr. Hilda Tusing; Asst. Treasurer – Dr. Natividad Mendoza; PRO – Dr. Salve Clavos; and Auditor – Dr. Rudita Divinagracia. Lay officers comprising the board together with the officers are: A. Flores, Araceli Florendo, and Paz Balderas.

Laguna Chapter

President – Dr. Mona Liza Cosme; Vice President – Ms. Lourdes Layos; Secretary – Ms. Nilda C. Francia; Asst. Secretary – Ms. Tita Almadin; Treasurer – Ms. Loida Macalinao; Asst. Treasurer – Ms. Neldy Jeneen; Auditor – Dr. Antonio Chua; PRO – Ms. Ruby Patiag. Comprising the Board of Directors aside from the officers are: Ms. Tess Bonzon, Ms. Olga Yanesa, Dr. Joselito Teodoro, Dr. Cenon San Pedro, Dr. Gil de la Cruz, and Dr. Lorna Labutong.

Albay Chapter

President – Dr. Keith I. Atutubo; Vice President – Dr. Juan S. Estevez; Treasurer – Dr. Lina R. Asido; Secretary – Ms. Rosario C. Coralde; PRO – Dr. Ma. Rosalinda A. Castro. The other Board members are: Dr. Mercedes A. Abunto, Dr. Rudicendo Roces, Mr. Rodolfo Ballerda, Dr. Merle A. Camba and Mr. Frank Yap.

Sorsogon Chapter

President – Dr. Amado H. Jose; Vice President – Dr. Ruben Lelis; Secretary – Dr. Claro Lopez, and Treasurer – Dr. Rosario Diesta. The members of the Board aside from the officers are: Dr. Jose Basa, Dr. Rowan Estrellado, Monsignor Pura, Dr. Jaime Co and Ms. Constancia Ramos.

A Word of Sympathy

The Board of Directors and the general membership of the Philippine Diabetes Association wish to commiserate with the victims of the recent killer quake, especially with the members of the PDA Chapters in Pangasinan, Baguio City, Nueva Ecija and Cagayan, who may have been personally affected. We have offered prayers for their safety.

THE INTERNATIONAL DIABETES FEDERATION

is pleased to announce a
diabetes leadership course
for primary health professionals

Planning and Delivery of Diabetes Care

Place: Leuven, Belgium

Date: 26 November - 7 December, 1990

Criteria: 32 participants will be chosen to attend from among physicians, nurses, dieticians, and others active in primary diabetes care.

Priority will be given to candidates from developing countries.

The working language will be English.

Participants will be provided with travel and accommodations.

Participants will be expected to contribute to the development of new diabetes care models upon return to their home country.

Course Description

The Course will be organized around three main subjects:

Epidemiology and diabetes awareness
Diabetes care models
Diabetes program development

Members of the faculty will be experts in the field and representative of IDF regions.

Application forms may be obtained from:

IDF Executive Office
40 rue Washington
1050 Brussels
Belgium
Attn: Hilary Williams, Secretary

Deadline for receipt of completed applications is 1 September 1990.

This course is sponsored by a major educational grant from Becton Dickinson